Senate Committee On

HEALTH, AGING, AND LONG-TERM CARE

SELECT SUBCOMMITTEE ON MEDICAID PRESCRIPTION DRUG OVER-PRESCRIBING

Burt L. Saunders, Chair

Meeting Packet

Tuesday, February 3, 2004
11:15 a.m. – 1:45 p.m.
37 Senate Office Building

(Please bring this packet to the committee meeting. Duplicate materials will not be available.)

A G E N D A

SELECT SUBCOMMITTEE ON MEDICAID PRESCRIPTION DRUG OVER-PRESCRIBING

Senator Burt L. Saunders, CHAIR

DATE: Tuesday, February 3, 2004
TIME: 11:15 a.m. -- 1:45 p.m.
PLACE: Room 37 (LL), Senate Office Building

MEMBERS: Senator Aronberg
Senator Fasano

TAB	BILL NO. AND INTRODUCER	BILL DESCRIPTION AND SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
		Consideration of recommended solutions to problems related to the over-prescribing of prescription drugs paid through the Florida Medicaid program and adoption of subcommittee recommendations.	

Agency for Health Care Administration

Senate Select Sub-Committee on Medicaid Prescription Drug Over-Prescribing

Further Proposed Statutory Changes in Addition to SB 1064:

- Section 409.913(3), F.S. (Prepayment Review)

  The agency may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective purchasing, that billing by a provider to the agency is in accordance with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law~~,~~ and ~~provision of~~ appropriate care to Medicaid recipients. Such prepayment reviews may be conducted of claims submitted but not yet paid as well as claims that have been processed for payment but not yet paid to the provider. Prepayment reviews shall be conducted as determined appropriate by the agency, without any suspicion or allegation of fraud, abuse, or neglect~~.~~, and may last for up to one year. Unless the agency has reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial or payment within 90 days from the date complete documentation is received by the Agency for review. If there is reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial or payment within 180 days from the date complete documentation is received by the Agency for review.

- Section 409.912, F.S. (Provider Lock-In)

  (45) The agency may mandate a recipient's participation in a provider lock-in program limiting the receipt of goods or services to a single provider. The lock-in programs shall include, but are not limited to pharmacies and physicians.

- Section 409.912(16)(b), F.S. (Prescription Pattern Review Panel)

  The responsibility of the agency under this subsection shall include the development of capabilities to identify actual and optimal practice patterns; patient and provider educational initiatives; methods for determining patient compliance with prescribed treatments; fraud, waste, and abuse prevention and detection programs; and beneficiary case management programs.

  1. The practice pattern identification program shall evaluate practitioner prescribing patterns based on national and regional practice guidelines, comparing practitioners to their peer groups. The agency and its Drug Utilization Review Board shall consult with the Department of Health and a panel of practicing health care professionals consisting of the following: the Speaker of the House of Representatives and the President of the Senate shall each appoint three physicians licensed under chapter 458 or chapter 459; and the Governor shall appoint two pharmacists licensed under chapter 465 and one dentist licensed

under chapter 466 who is an oral surgeon. Terms of the panel members shall expire at the discretion of the appointing official. The panel shall begin its work by August 1, 1999, regardless of the number of appointments made by that date. The advisory panel shall be responsible for evaluating treatment guidelines and recommending ways to incorporate their use in the practice pattern identification program. Practitioners who are prescribing inappropriately or inefficiently, as determined by the agency, may have their prescribing of certain drugs subject to prior authorization or may be terminated from all participation in the Medicaid program.

- Section 465.188, F.S. (Pharmacy Audits)

  (1) Notwithstanding any other law, when an audit of the Medicaid-related records of a pharmacy licensed under chapter 465 is conducted, such audit must be conducted as provided in this section.

  ~~(a) The agency conducting the audit must give the pharmacist at least 1 week's prior notice of the audit.~~

  The audit criteria set forth in this section shall apply only to audits of claims submitted for payment subsequent to July 11, 2003.

Governor's Initiatives:

- Restructure Medicaid Program Integrity Efforts
- Expansion of Wireless Handheld PDA Program – (Gold Standard Project)
- Authorization of Provider Network Controls
- Prior Authorize Off-label Uses of Prescribed Drugs
- Decrease Selected Prescribed Drugs to One Dose Per Day
- Establish Therapy Guidelines for Selected Drug Categories

Opportunities for Improvement

Interagency Coordination

- Medicaid Fraud Control Unit (MFCU)
  - To intensify our data analysis activities
  - To develop additional indicators for recognizing potential fraud

- To identify opportunities for additional training
- To increase our sharing of information
- To update our Memorandum of Understanding

- Department of Health (DOH)
  - To ensure that we have the systems in place to exchange license status information
  - To ensure the timely notification to AHCA of provider actions taken by DOH

Data Sharing Agreements

- Medicaid Fraud Control Unit
- Department of Law Enforcement
- Department of Health

Federal Coordination

At the request of Chairman Saunders, the Agency is working with committee staff to develop model Federal legislation to enhance states' ability to sanction recipients when they abuse the system.

Additional Resource Requirements

The Agency is requesting additional needs to implement the proposed statutory changes and to further our efforts in addressing over-prescribing in the Medicaid program. The committee will be receiving a separate list of these needs for your consideration.

Agency for Health Care Administration
Additional Resource Requirements for
Medicaid Fraud and Abuse Related Functions

Area	Description	Resource Requirement
Pharmacy Lock In	Additional staff to manage a greatly expanded pharmacy lock in population; functions include beneficiary prescribed drug use analyses, pharmacy notice of beneficiary lock in, beneficiary notice of lock in status, beneficiary appeals, and beneficiary monitoring; system modifications; and coordination/work with contractor regarding beneficiary/provider profiling	3.0 FTEs
Other Provider Lock In/MediPass Controls	Additional staff to establish and manage a lock in program for other providers; design, implement, and manage additional controls in the MediPass program to ensure non-PCP care is authorized and managed. Functions include beneficiary use analyses; beneficiary notice of lock in status, pharmacy notice of beneficiary lock in; handling of beneficiary appeals; beneficiary monitoring; system modifications; and coordination/work with contractor regarding beneficiary/provider profiling	2.0 FTEs
Provider Network Management	Additional staff to determine provider network requirements, analyze provider participation, profile provider revenues	2.0 FTEs
Technology Planning	Additional staff to assess health care-related care technological developments and enhanced technology use related to fraud and abuse detection techniques, beneficiary and provider profiling/data mining, dissemination of claims data, medical records, and real-time service use tracking	1.0 FTE
Drug Benefit Management – Algorithm Development	Funding to contract for the development of therapy guidelines, clinical review tools and algorithms to manage drug use and promote cost effective, best practices	$200,000
Prescribed Drug Cost Control Planning	Funding to contract for prescribed drug cost control planning; the contractor would be responsible for reviewing other state, federal, and other payer practices; identifying best practices; analyzing and forecasting the effects of various additional drug cost controls; assessing the effectiveness of current controls; identifying potential drug fraud and abuse schemes and system deficiencies in detecting	$150,000

Medicaid
1-16-04

MPI	Additional staff to increase the field detection and data analysis operations of MPI. On-site visits and focus reviews to verify data collected through the analysis of suspect billings are an important part of the early detection of billing schemes. An increase in the detection and prevention activities in the MPI field offices in Miami, Tampa, Orlando and Jacksonville would result in a more focused and effective strategy for dealing with these abuses.	5.0 FTEs
General Counsel's Office	An additional attorney is needed to handle an increased number of cases resulting from increased MPI field detection operations. Also, another additional attorney is needed to handle litigation resulting from the expanded lock-in program, an anticipated increase in terminations, and increased detection efforts specifically directed at recipient-fraud issues. A staff person will be needed to assist the attorneys.	3.0 FTEs

Federal Statutory Barriers to Medicaid Anti-Fraud Initiatives

Medicaid Beneficiaries

Criminal and Civil Penalties for Beneficiary Fraud

Current Status

Section 1128B of the Social Security Act provides for criminal penalties for acts involving federal health care programs, and allows for suspension of Medicaid benefits for up to one year, of individuals convicted of certain federal crimes.

Federal Proposal

Amend 42 U.S.C. 1320a-7b to include that the administrator of a Federal health care program may limit, restrict, or suspend the Medicaid eligibility of individuals convicted of offenses under state law for acts involving federal health care programs, including the following: drug trafficking; trafficking in other goods and supplies paid for by Medicaid; illegal use of a Medicaid identification card; illegal transfer of a Medicaid identification card; doctor shopping for the purpose of illegally obtaining controlled substances; altering a prescription; intentionally receiving duplicative, excessive, contraindicated or conflicting health care services for personal gain; and misrepresenting symptoms or conditions to receive unnecessary medical care, goods or supplies.

Authorize imposition of fines, longer periods of suspension, and termination of Medicaid benefits for individuals convicted of offenses set forth in 42 U.S.C. 1320a-7b.

Authorize the administrator of a Federal health care program to impose fines and penalties (including restriction/suspension/termination of benefits) upon the conviction in state or federal court of an individual for acts involving federal public assistance programs.

Through federal legislation or state rulemaking, categorize types of convictions that affect Medicaid eligibility, and apply penalties as appropriate. For example, a conviction for altering a prescription could be considered a "Level 3" conviction affecting eligibility, the penalty being a restriction of benefits for a period of time deemed reasonable according to the nature of the offense. Restrictions could include denial of payment for certain classes of drugs. A conviction for illegal use of a Medicaid identification card could be considered a "Level 2" conviction affecting eligibility, the penalty being suspension of all Medicaid benefits for a reasonable period of time.

Administrative Remedies for Beneficiary Fraud

Current Status

Federal Medicaid law only authorizes criminal prosecution of beneficiary fraud, and does not authorize administrative remedies by the administering agency. This makes the process for sanctioning much more expensive and time consuming, which serves as a barrier to prosecution unless fraud cases are for very large dollar amounts.

Under federal guidelines for TANF and the Food Stamp Program, administrative remedies for beneficiary fraud currently exist. The Department of Children and Families (DCF) has hearing officers that conduct hearings on beneficiary fraud and abuse of

these programs, and has a Benefit Recoveries Program that establishes overpayment receivables as a result. DCF also has program disqualification as part of the sanction/recovery process. Similar authority for administrative remedies for fraud or abuse committed by Medicaid beneficiaries would reduce the cost and resources associated with seeking sanctions or recovery through the courts system.

Federal Proposal

Amend federal legislation to authorize an administrative remedy process for Medicaid, which would allow for more coordinated action between the Agencies in taking action for beneficiary fraud and abuse, and would allow for a less costly and complex process for levying sanctions.

Through federal legislation or state rulemaking, allow imposition of the following sanctions:

- Restriction of certain benefits
- Suspension of benefits
- Termination of benefits
- Restitution
- Fines

Restriction of Freedom of Choice of Providers

Current Status

Under Section 1915(a) of the Social Security Act, and Title 42 Code of Federal Regulations 431.54, states are permitted to enroll beneficiaries suspected of fraud/abuse/misuse of benefits into a pharmacy or physician lock-in program. However, 1902(a)(23) of the Social Security Act provides that Medicaid eligible beneficiaries must be allowed to obtain benefits from any willing and qualified provider. Notwithstanding the provisions in 1915(a), waiver of this section is permitted through 1915(b) of the Social Security Act; however, the waiver process is burdensome, both on time and resources.

Proposal

Amend federal legislation to grant broader authority to states to limit Medicaid beneficiaries' freedom of choice of providers to preferred/enrolled providers, and to expand a state's ability to limit provider networks through expedition or elimination of the 1915(b) waiver process.

Medicaid Providers

Any Willing Provider

Current Status

Section 1902(a)(23) of the Social Security Act provides that beneficiaries may obtain services from any qualified Medicaid provider that undertakes to provide the services to them. Specifically, subsection 23 states that a State plan for medical assistance must provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides

such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services . . . except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan. See also 42 C.F.R. 431.51(b).

However, there is an exception to the general freedom of choice rule. 42 U.S.C. 1396n provides that a State shall not be found out of compliance with 1396a solely because the State imposes certain specified allowable restrictions on freedom of choice. In addition, federal regulations provide that states may interfere with a beneficiary's freedom of choice by "[s]etting reasonable standards relating to the qualifications of providers." 42 C.F.R. 431.51(c)(2). Some of the reasons for restricting provider enrollment that may be deemed reasonable include (1) the protection of beneficiaries by allowing the state to exercise some degree of control over providers, (2) assisting the state in properly allocating scarce public resources, (3) preventing fraud, and (4) promoting good service. See Nutritional Support Services v. Miller, 806 F.Supp. 977, 979 (N.D. Ga. 1992); Macombs Pharmacy, Inc. v. Wing, 1998 U.S. Dist. Lexis 15664 (S.D. N.Y. 1998) (court held that denying an applicant enrollment in the Medicaid program on the grounds that there was no need for an additional provider in the geographical area in which the applicant was located was rationally related to the legitimate government interests of preventing fraud and promoting good services).

In addition, courts have concluded that Section 1902(a)(23) does not create a right of action for providers. See, e.g., Silver v. Baggiano, 804 F.2d 1211, 1215 (11th Cir. 1986) (court held that "there is no indication in the language [of the Act] that health care practitioners are given any rights by this provision"); Catanzano v. Wing, 992 F.Supp. 593, 595 (W.D. N.Y. 1998)(1902(a)(23) was "intended to confer rights upon health care beneficiaries, not providers"); Nutritional Support Services v. Miller, 826 F.Supp. 467, 470 (N.D. Ga. 1993)(court concluded that durable medical equipment providers could not assert a § 1983 claim for violation of 1902(a)(23)).

Although courts have interpreted 1902(a)(23) of the Social Security Act in various ways, the language of the current federal statutes limits states' options in restricting willing and qualified providers from participating in Medicaid. 1915(b) of the Social Security Act allows for waiver of 1902(a)(23) through a formal application process, which is often burdensome and costly to states.

Federal Proposal

Modify 1902(a)(23) "Any Willing, Qualified Provider" provisions, and other pertinent provisions of the Social Security Act, to clarify states' rights in the area of provider network controls. Expand states' ability to limit provider networks through expedition or elimination of the 1915(b) waiver process.

Provider Over-Payments

Current Status

42 CFR 433.316(d) states that "An overpayment that results from fraud or abuse is discovered (and therefore reported to the federal Centers for Medicare and Medicaid Services, or CMS) on the date of the final written notice of the State's overpayment

determination that a Medicaid agency official or other State official sends to the provider." The result of this has been that the Agency is required to record billings to providers upon issuance of a Final Audit letter, and to refund the federal portion of the amount owed by the provider prior to the appellate process.

Collecting debts owed to the state is a difficult process. For various reasons (bankruptcy, refusal to pay, imprisonment of debtor) the amount billed on the Final Audit letter may not be collected. Additionally, the amount due may be reduced by the Appellate process.

Proposal

Revise federal legislation to allow for the recording and refunding of the overpayment at the time all appellate and collection efforts are exhausted. This would require changing the Code of Federal Regulations reporting requirements from "date of final written notice" to "the date of the final notice of amount due that a Medicaid agency or other State official sends to the provider in which no appeal is pending or after resolution of the appellate proceeding."

Bankruptcy

Current Status

- Medicaid overpayment claims are unsecured claims in the bankruptcy of a provider. [11 U.S.C. §§ 101(5), 506]
- Medicaid overpayment claims are not granted a priority over the claims of other creditors. [11 U.S.C. § 507]
- Whether the case is a Chapter 7 liquidation, Chapter 11 reorganization, or Chapter 13 individual payment plan, Medicaid only receives a pro rata share of the distribution to general unsecured creditors. [11 U.S.C. §§ 726, 1129, 1325]
- In bankruptcies under Chapters 7 or 11, a bankrupt Medicaid provider may not discharge liability for Medicaid overpayments obtained by fraud, false pretenses, false representation, or larceny. [11 U.S.C. §523(a)(2), (4)] However, to enforce these exceptions to discharge the State would have to bring a separate suit against the debtor in the bankruptcy court, waiving the State's sovereign immunity on these issues.
- Debtors may discharge liability for Medicaid overpayments obtained by fraud in Chapter 13 individual payment plans, except for those restitution liabilities imposed by a criminal conviction. [11 U.S.C. §1328]

Proposal to Improve Recovery of Medicaid Overpayments from Bankrupt Providers

- State law: Require the provider to grant a lien in property to secure obligation to repay overpayments. This would make the State a secured bankruptcy creditor.
- Create an exception to discharge under 11 U.S.C. §523 providing that Medicaid overpayments determined in State civil, criminal, or administrative proceedings may not be discharged under 11 U.S.C. §§ 727 and 1141, and must be paid in full for a debtor to receive a discharge in a Chapter 13 case.
- Modify the automatic stay under 11 U.S.C. §362 to allow the State to pursue proceedings to adjudicate the amount of a Medicaid overpayment but not permitting collection of the overpayment other than by State law recoupment.

- Modify the automatic stay under 11 U.S.C. §362 to acknowledge the rights of Medicare and the state Medicaid programs to recoup overpayments against current and future payments.
- Modify 11 U.S.C. §507 by giving state Medicaid overpayments at least an eighth priority (above unpaid taxes) in payment. This will require payment in full or satisfactory treatment of all Medicaid overpayments claims prior to any payment to general unsecured creditors.

General

Data Sharing

Current Status

An agreement is currently in place under which CMS will conduct a computer matching program with the State of Florida, Agency for Health Care Administration (AHCA) to study claims, billing, and eligibility information to detect suspected instances of Medicare and Medicaid fraud and abuse (F&A) in the State of Florida. CMS and AHCA will provide TriCenturion, a CMS contractor for the Medicare and Medicaid programs, records pertaining to eligibility, claims, and billing which TriCenturion will match in order to merge the information into a single database. Utilizing fraud detection software, the information will then be used to identify patterns of aberrant practices requiring further investigation.

Proposal

Florida is one of six states to participate in this matching program and this contract is in effect for 18 months after the execution, expected to be in April 2004. The Agency believes that this national project should be made permanent and extended to all states to assist in identifying duplicate payments, duplicate services and much more.

Federal Funding

Current Status

Currently, Medicaid Program Integrity functions receive approximately 50% federal matching funds.

Proposal

Federal matching for Medicaid Program Integrity (MPI) functions should be increased to 90% federal matching for MPI system and other development activities, and 75% federal matching for MPI operations. The Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General currently receives an enhanced federal match (75-90%) for its fraud functions. By increasing the federal matching funds to align with that of MFCU, MPI would be able to increase its investigative abilities and resources to monitor aberrant billings and look at possible fraud and abuse in more detail.

RECOMMENDATIONS FROM THE ATTORNEY GENERAL'S OFFICE

A bill to be entitled

An act relating to Medicaid fraud; creating s. 409.9201, F.S.; providing definitions; providing that a person who sells or attempts to sell legend drugs obtained through the Medicaid program commits a felony; providing that a person who purchases or attempts to purchase legend drugs obtained through the Medicaid program and intended for the use of another commits a felony; providing that a person who makes or conspires to make false representations for the purpose of obtaining goods or services from the Medicaid program commits a felony; providing specified criminal penalties depending on the value of the legend drugs or goods or services obtained from the Medicaid program; creating s. 812.0191, F.S.; providing definitions; providing that a person who traffics in property paid for in whole or in part by the Medicaid program, or who finances, directs, or traffics in such property, commits a felony; providing specified criminal penalties depending on the value of the property; amending s. 16.56, F.S.; adding criminal violations of ch. 409, F.S., to the list of specified crimes within the jurisdiction of the Office of Statewide Prosecution; amending s. 409.912, F.S; requiring that abusers and over-users of the Medicaid program be enrolled in a disease-management or drug-benefit-management

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program; directing that enrollment in the program is mandatory; amending s. 409.913, F.S.; clarifying that only prescriptions, medical supplies, or medical services ordered by an authorized Medicaid provider are reimbursable from the Medicaid program; providing an exception for bona fide medical emergencies; prohibiting the Medicaid program from paying any claim not meeting specified criteria; amending s. 895.02, F.S.; adding Medicaid recipient fraud to the definition of the term "racketeering activity"; amending s. 905.34, F.S.; adding any criminal violation of ch. 409, F.S., to the list of crimes within the jurisdiction of the statewide grand jury; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 409.9201, Florida Statutes, is created to read:

409.9201 Medicaid fraud.--

(1) As used in this section, the term:

(a) "Legend drug" means any drug, including, but not limited to, finished dosage forms or active ingredients that are subject to, defined by, or described by s. 503(b) of the Federal Food, Drug, and Cosmetic Act or by s. 465.003(8), s. 499.007(12), or s. 499.0122(1)(b) or (c).

(b) "Value" means the amount billed to the Medicaid program for the property dispensed or the market value of a legend drug or goods or services at the time and place of the

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offense. If the market value cannot be determined, the term means the replacement cost of the legend drug or goods or services within a reasonable time after the offense.

(2) Any person who sells, who attempts or conspires to sell, or who causes any other person to sell or attempt or conspire to sell a legend drug that was paid for by the Medicaid program commits a felony.

(a) If the value of the legend drug is less than $20,000, the crime is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) If the value of the legend drug is $20,000 or more but less than $100,000, the crime is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) If the value of the legend drug involved is $100,000 or more, the crime is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

The value of individual items of the legend drugs or goods or services involved in distinct transactions committed during a single scheme or course of conduct, whether involving a single person or several persons, may be aggregated when determining the punishment for the offense.

(3) Any person who purchases, or attempts or conspires to purchase, a legend drug that was paid for by the Medicaid program and intended for use by another person commits a felony.

(a) If the value of the legend drug is less than $20,000, the crime is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) If the value of the legend drug is $20,000 or more but less than $100,000, the crime is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) If the value of the legend drug is $100,000 or more, the crime is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(4) Any person who makes or causes to be made, or who attempts or conspires to make, any false statement or representation to any person for the purpose of obtaining goods or services from the Medicaid program commits a felony.

(a) If the value of the goods or services is less than $20,000, the crime is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) If the value of the goods or services is $20,000 or more but less than $100,000, the crime is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) If the value of the goods or services involved is $100,000 or more, the crime is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 2. Section 812.0191, Florida Statutes, is created to read:

812.0191 Dealing in property paid for in whole or in part by the Medicaid program.--

(1) As used in this section, the term:

(a) "Property paid for in whole or in part by the Medicaid program" means any devices, goods, services, drugs, or any other property furnished or intended to be furnished to a recipient of benefits under the Medicaid program.

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(b) "Value" means the amount billed to Medicaid for the property dispensed or the market value of the devices, goods, services, or drugs at the time and place of the offense. If the market value cannot be determined, the term means the replacement cost of the devices, goods, services, or drugs within a reasonable time after the offense.

(2) Any person who traffics in, or endeavors to traffic in, property that he or she knows or should have known was paid for in whole or in part by the Medicaid program commits a felony.

(a) If the value of the property is less than $20,000, the crime is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) If the value of the property involved is $20,000 or more but less than $100,000, the crime is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) If the value of the property involved is $100,000 or more, the crime is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

The value of individual items of the devices, goods, services, drugs, or other property involved in distinct transactions committed during a single scheme or course of conduct, whether involving a single person or several persons, may be aggregated when determining the punishment for the offense.

(3) Any person who initiates, organizes, plans, finances, directs, manages, or supervises the obtaining of property paid for in whole or in part by the Medicaid program and who traffics in, or endeavors to traffic in, such property

commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 3. Subsection (1) of section 16.56, Florida Statutes, is amended to read:

16.56 Office of Statewide Prosecution.--

(1) There is created in the Department of Legal Affairs an Office of Statewide Prosecution. The office shall be a separate "budget entity" as that term is defined in chapter 216. The office may:

(a) Investigate and prosecute the offenses of:

1. Bribery, burglary, criminal usury, extortion, gambling, kidnapping, larceny, murder, prostitution, perjury, robbery, carjacking, and home-invasion robbery;

2. Any crime involving narcotic or other dangerous drugs;

3. Any violation of the provisions of the Florida RICO (Racketeer Influenced and Corrupt Organization) Act, including any offense listed in the definition of racketeering activity in s. 895.02(1)(a), providing such listed offense is investigated in connection with a violation of s. 895.03 and is charged in a separate count of an information or indictment containing a count charging a violation of s. 895.03, the prosecution of which listed offense may continue independently if the prosecution of the violation of s. 895.03 is terminated for any reason;

4. Any violation of the provisions of the Florida Anti-Fencing Act;

5. Any violation of the provisions of the Florida Antitrust Act of 1980, as amended;

6. Any crime involving, or resulting in, fraud or deceit upon any person;

7. Any violation of s. 847.0135, relating to computer pornography and child exploitation prevention, or any offense related to a violation of s. 847.0135;

8. Any violation of the provisions of chapter 815; ~~or~~

9. Any criminal violation of part I of chapter 499; or

10. Any criminal violation of chapter 409.

or any attempt, solicitation, or conspiracy to commit any of the crimes specifically enumerated above. The office shall have such power only when any such offense is occurring, or has occurred, in two or more judicial circuits as part of a related transaction, or when any such offense is connected with an organized criminal conspiracy affecting two or more judicial circuits.

(b) Upon request, cooperate with and assist state attorneys and state and local law enforcement officials in their efforts against organized crimes.

(c) Request and receive from any department, division, board, bureau, commission, or other agency of the state, or of any political subdivision thereof, cooperation and assistance in the performance of its duties.

Section 4. Paragraph (a) of subsection (40) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed

to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency may establish prior authorization requirements for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization.

(40)(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:

1. Medicaid prescribed-drug coverage for brand-name drugs for adult Medicaid recipients is limited to the dispensing of four brand-name drugs per month per recipient. Children are exempt from this restriction. Antiretroviral agents are excluded from this limitation. No Requirements for prior authorization or other restrictions on medications used to treat mental illnesses such as schizophrenia, severe depression, or bipolar disorder may <u>not</u> be imposed on Medicaid recipients. Medications that will be available without restriction for persons with mental illnesses include atypical antipsychotic medications, conventional antipsychotic medications, selective serotonin reuptake inhibitors, and other medications used for the treatment of serious mental illnesses. The agency shall also limit the amount of a

prescribed drug dispensed to no more than a 34-day supply. The agency shall continue to provide unlimited generic drugs, contraceptive drugs and items, and diabetic supplies. Although a drug may be included on the preferred drug formulary, it would not be exempt from the four-brand limit. The agency may authorize exceptions to the brand-name-drug restriction based upon the treatment needs of the patients, only when the ~~such~~ exceptions are based on prior consultation provided by the agency or an agency contractor, but the agency must establish procedures to ensure that:

a. There will be a response to a request for prior consultation by telephone or other telecommunication device within 24 hours after receipt of a request for prior consultation;

b. A 72-hour supply of the drug prescribed will be provided in an emergency or when the agency does not provide a response within 24 hours as required by sub-subparagraph a.; and

c. Except for the exception for nursing home residents and other institutionalized adults and except for drugs on the restricted formulary for which prior authorization may be sought by an institutional or community pharmacy, prior authorization for an exception to the brand-name-drug restriction is sought by the prescriber and not by the pharmacy. When prior authorization is granted for a patient in an institutional setting beyond the brand-name-drug restriction, the ~~such~~ approval is authorized for 12 months and monthly prior authorization is not required for that patient.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the average wholesale price less 13.25 percent.

3. The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The management process may include, but is not limited to, comprehensive, physician-directed medical-record reviews, claims analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and drug therapies. The agency may contract with a private organization to provide drug-program-management services. The Medicaid drug benefit management program shall include initiatives to manage drug therapies for HIV/AIDS patients; patients using 20 or more unique prescriptions in a 180-day period; ~~and~~ the top 1,000 patients in annual spending; and patients identified as abusers or over-users. Enrollment in this program is mandatory for all recipients in these categories.

4. The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation, disease-management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment when it is determined that it has a sufficient number of Medicaid-participating providers.

5. The agency shall develop and implement a program that requires Medicaid practitioners who prescribe drugs to use a counterfeit-proof prescription pad for Medicaid

prescriptions. The agency shall require the use of standardized counterfeit-proof prescription pads by Medicaid-participating prescribers or prescribers who write prescriptions for Medicaid recipients. The agency may implement the program in targeted geographic areas or statewide.

6. The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. These arrangements shall require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level.

7. The agency may establish a preferred drug formulary in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the establishment of such formulary, it is authorized to negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 10 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 25 percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage will guarantee a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug formulary. However, a pharmaceutical

manufacturer is not guaranteed placement on the formulary by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency is authorized to contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" may include, at the agency's discretion, cash rebates and other program benefits that offset a Medicaid expenditure. Such other program benefits may include, but are not limited to, disease management programs, drug product donation programs, drug utilization control programs, prescriber and beneficiary counseling and education, fraud and abuse initiatives, and other services or administrative investments with guaranteed savings to the Medicaid program in the same year the rebate reduction is included in the General Appropriations Act. The agency is authorized to seek any federal waivers to implement this initiative.

8. The agency shall establish an advisory committee for the purposes of studying the feasibility of using a restricted drug formulary for nursing home residents and other institutionalized adults. The committee shall be comprised of seven members appointed by the Secretary of Health Care Administration. The committee members shall include two physicians licensed under chapter 458 or chapter 459; three pharmacists licensed under chapter 465 and appointed from a list of recommendations provided by the Florida Long-Term Care Pharmacy Alliance; and two pharmacists licensed under chapter 465.

9. The Agency for Health Care Administration shall expand home delivery of pharmacy products. To assist Medicaid patients in securing their prescriptions and reduce program costs, the agency shall expand its current mail-order-pharmacy diabetes-supply program to include all generic and brand-name drugs used by Medicaid patients with diabetes. Medicaid recipients in the current program may obtain nondiabetes drugs on a voluntary basis. This initiative is limited to the geographic area covered by the current contract. The agency may seek and implement any federal waivers necessary to implement this subparagraph.

Section 5. Subsection (7) of section 409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.--The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement

agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must recommend changes necessary to prevent or recover overpayments. For the 2001-2002 fiscal year, the agency shall prepare a report that contains as much of this information as is available to it.

(7)(a) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

1.~~(a)~~ Have actually been furnished to the recipient by the provider prior to submitting the claim.

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2.~~(b)~~ Are Medicaid-covered goods or services that are medically necessary.

3.~~(c)~~ Are of a quality comparable to those furnished to the general public by the provider's peers.

4.~~(d)~~ Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as are authorized by the agency.

5.~~(e)~~ Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.

6.~~(f)~~ Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

(b)1. Except in an instance involving a bona fide emergency, a physician who is not an authorized Medicaid provider may not prescribe medications, medical supplies, or medical services to a Medicaid recipient when the physician knows or should know that a claim for reimbursement of any portion of the cost of the prescribed medications, medical supplies, or medical services will be submitted to the Florida Medicaid program.

2. Except in an instance involving a bona fide emergency, a vendor of prescription medications, medical supplies, or medical services otherwise authorized to submit claims for Medicaid reimbursements may not submit a claim for Medicaid reimbursement when the vendor knows or should know

that the physician prescribing the medications, medical supplies, or medical services is not an authorized Medicaid provider.

shall also

3. Any person who knowingly violates this chapter or knowingly participates in a plan or scheme to cause others to violate this chapter shall reimburse the Florida Medicaid program for the full amount of each Medicaid claim submitted in violation of this chapter. The person shall also be subject to penalties equal to three times the amount of each unlawful Medicaid claim submitted, along with civil penalties of up to $5,000 for each Medicaid claim submitted for medications, medical equipment, or medical services in violation of this chapter, as well as the investigation and prosecution costs and attorney's fees. The remedies in this subparagraph are in addition to any remedy otherwise available for the same conduct.

(c) The agency may not reimburse a person for any Medicaid claim that does not meet all of the criteria in this subsection.

Section 6. Paragraph (a) of subsection (1) of section 895.02, Florida Statutes, is amended to read:

895.02 Definitions.--As used in ss. 895.01-895.08, the term:

(1) "Racketeering activity" means to commit, to attempt to commit, to conspire to commit, or to solicit, coerce, or intimidate another person to commit:

(a) Any crime which is chargeable by indictment or information under the following provisions of the Florida Statutes:

1. Section 210.18, relating to evasion of payment of cigarette taxes.

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2. Section 403.727(3)(b), relating to environmental control.

3. Section 414.39, relating to public assistance fraud.

4. Section 409.920, relating to Medicaid provider fraud and s. 409.9201, relating to Medicaid recipient fraud.

5. Section 440.105 or s. 440.106, relating to workers' compensation.

6. Sections 499.0051, 499.0052, 499.0053, 499.0054, and 499.0691, relating to crimes involving contraband and adulterated drugs.

7. Part IV of chapter 501, relating to telemarketing.

8. Chapter 517, relating to sale of securities and investor protection.

9. Section 550.235, s. 550.3551, or s. 550.3605, relating to dogracing and horseracing.

10. Chapter 550, relating to jai alai frontons.

11. Chapter 552, relating to the manufacture, distribution, and use of explosives.

12. Chapter 560, relating to money transmitters, if the violation is punishable as a felony.

13. Chapter 562, relating to beverage law enforcement.

14. Section 624.401, relating to transacting insurance without a certificate of authority, s. 624.437(4)(c)1., relating to operating an unauthorized multiple-employer welfare arrangement, or s. 626.902(1)(b), relating to representing or aiding an unauthorized insurer.

15. Section 655.50, relating to reports of currency transactions, when such violation is punishable as a felony.

16. Chapter 687, relating to interest and usurious practices.

17. Section 721.08, s. 721.09, or s. 721.13, relating to real estate timeshare plans.

18. Chapter 782, relating to homicide.

19. Chapter 784, relating to assault and battery.

20. Chapter 787, relating to kidnapping.

21. Chapter 790, relating to weapons and firearms.

22. Section 796.03, s. 796.04, s. 796.05, or s. 796.07, relating to prostitution.

23. Chapter 806, relating to arson.

24. Section 810.02(2)(c), relating to specified burglary of a dwelling or structure.

25. Chapter 812, relating to theft, robbery, and related crimes.

26. Chapter 815, relating to computer-related crimes.

27. Chapter 817, relating to fraudulent practices, false pretenses, fraud generally, and credit card crimes.

28. Chapter 825, relating to abuse, neglect, or exploitation of an elderly person or disabled adult.

29. Section 827.071, relating to commercial sexual exploitation of children.

30. Chapter 831, relating to forgery and counterfeiting.

31. Chapter 832, relating to issuance of worthless checks and drafts.

32. Section 836.05, relating to extortion.

33. Chapter 837, relating to perjury.

34. Chapter 838, relating to bribery and misuse of public office.

35. Chapter 843, relating to obstruction of justice.

36. Section 847.011, s. 847.012, s. 847.013, s. 847.06, or s. 847.07, relating to obscene literature and profanity.

37. Section 849.09, s. 849.14, s. 849.15, s. 849.23, or s. 849.25, relating to gambling.

38. Chapter 874, relating to criminal street gangs.

39. Chapter 893, relating to drug abuse prevention and control.

40. Chapter 896, relating to offenses related to financial transactions.

41. Sections 914.22 and 914.23, relating to tampering with a witness, victim, or informant, and retaliation against a witness, victim, or informant.

42. Sections 918.12 and 918.13, relating to tampering with jurors and evidence.

Section 7. Section 905.34, Florida Statutes, is amended to read:

905.34 Powers and duties; law applicable.--The jurisdiction of a statewide grand jury impaneled under this chapter shall extend throughout the state. The subject matter jurisdiction of the statewide grand jury shall be limited to the offenses of:

(1) Bribery, burglary, carjacking, home-invasion robbery, criminal usury, extortion, gambling, kidnapping, larceny, murder, prostitution, perjury, and robbery;

(2) Crimes involving narcotic or other dangerous drugs;

(3) Any violation of the provisions of the Florida RICO (Racketeer Influenced and Corrupt Organization) Act, including any offense listed in the definition of racketeering activity in s. 895.02(1)(a), providing such listed offense is

investigated in connection with a violation of s. 895.03 and is charged in a separate count of an information or indictment containing a count charging a violation of s. 895.03, the prosecution of which listed offense may continue independently if the prosecution of the violation of s. 895.03 is terminated for any reason;

(4) Any violation of the provisions of the Florida Anti-Fencing Act;

(5) Any violation of the provisions of the Florida Antitrust Act of 1980, as amended;

(6) Any violation of the provisions of chapter 815;

(7) Any crime involving, or resulting in, fraud or deceit upon any person;

(8) Any violation of s. 847.0135, s. 847.0137, or s. 847.0138 relating to computer pornography and child exploitation prevention, or any offense related to a violation of s. 847.0135, s. 847.0137, or s. 847.0138; ~~or~~

(9) Any criminal violation of part I of chapter 499; or

(10) Any criminal violation of chapter 409;

or any attempt, solicitation, or conspiracy to commit any violation of the crimes specifically enumerated above, when any such offense is occurring, or has occurred, in two or more judicial circuits as part of a related transaction or when any such offense is connected with an organized criminal conspiracy affecting two or more judicial circuits. The statewide grand jury may return indictments and presentments irrespective of the county or judicial circuit where the offense is committed or triable. If an indictment is returned, it shall be certified and transferred for trial to

the county where the offense was committed. The powers and duties of, and law applicable to, county grand juries shall apply to a statewide grand jury except when such powers, duties, and law are inconsistent with the provisions of ss. 905.31-905.40.

Section 8. This act shall take effect July 1, 2004.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

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SENATE SUMMARY

Provides that a person who sells or attempts to sell, or purchases or attempts to purchase, legend drugs or goods or services unlawfully obtained through the Medicaid program commits a felony. Provides specified criminal penalties depending on the value of the legend drugs or goods or services obtained. Provides that a person who traffics in property from the Medicaid program commits a felony. Provides specified criminal penalties depending on the value of the property. Adds criminal violations of ch. 409, F.S., to the list of specified crimes within the jurisdiction of the Office of Statewide Prosecution. Provides that abusers and over-users of the Medicaid program be enrolled in a disease management or drug benefit management program. Directs that enrollment in the program is mandatory. Clarifies that only prescriptions, medical supplies, or medical services ordered by a Medicaid enrolled provider are reimbursable from the Medicaid program. Provides an exception for bona fide medical emergencies. Prohibits the Medicaid program from paying any claims not meeting specified criteria. Adds Medicaid recipient fraud to the definition of racketeering activity. Adds any criminal violation of ch. 409, F.S., to the list of crimes within the jurisdiction of the statewide grand jury. (See bill for details.)

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

Draft Recommendations for Potential Amendments to Federal Law Regarding Medicaid Pharmaceutical Fraud

The following proposals are suggestions from the Medicaid Fraud Control Unit in the Office of the Attorney General and have not been reviewed by the federal agencies mentioned.

1. A definition of "Average Sales Price" added to federal law analogous to the definitions of average sales price provided in several current Department of Justice Corporate Integrity Agreements with manufacturers that arose from settlement negotiations (e.g., the recent Bayer and GlaxoSmithKline corporate integrity agreements). The newly enacted Medicare pharmacy bill has a definition of "Average Wholesale Price" but it is not particularly helpful for anti-fraud purposes. Perhaps an amendment to that new average wholesale price definition would be helpful.

2. A federal requirement for manufacturer certification of the prices that they report to First DataBank. The State of Texas has required certification under state law for many years, and California is considering the same. A federal law requiring price certification would be very helpful.

3. There appears to be some conflict between the legal requirements of the Food & Drug Administration and the Centers for Medicare and Medicaid Services (CMS) as to whether the unique identifier code of individual pharmaceuticals (the National Drug Code, or NDC) should be changed in the event the pharmaceutical is "rebottled" or "relabeled" after the manufacturer sells the drug. This is the process whereby very large containers of drugs are broken down into many, small, retail-distribution size containers. The FDA law appears to require the NDC to stay the same in the event of rebottling. Conversely, the CMS regulations seem to indicate that anytime a drug is rebottled, it must be assigned a new unique NDC. The significance of the matter lies in the federal/state Medicaid drug rebate program administered by CMS under 42 USC s. 1396r-8 (manufacturers pay a percentage of Medicaid's initial cost back to the states as a rebate). Rebottling increases the ultimate cost of the drugs, which increases the amount of the drug rebate paid to the states. Manufacturers ignore the CMS law and hide behind the FDA law when paying rebate on rebottled drugs because it allows them to pay a lower rebate on an unchanged NDC. Thus, Medicaid pays for high-priced "small-bottle" dispensing, but the manufacturers pay lower-cost "big-bottle" Medicaid rebates.

Department of Health Recommended Changes

Statutory

Create s. 456.072(1)(ff), Florida Statutes:

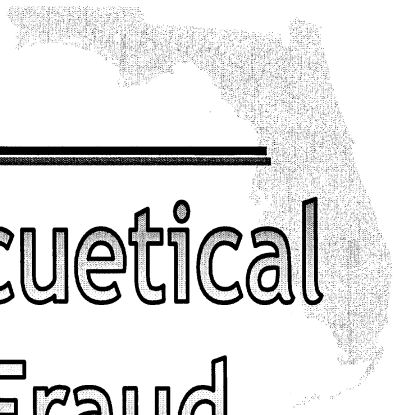
> 456.072(1)(ff) Engaging in a practice pattern which demonstrates a lack of reasonable skill and safety to patients, a violation of any provision of this chapter, a violation the applicable practice act, or a violation of any rules adopted pursuant thereto.

This would allow the Department of Health to investigate and discipline for bad practice patterns which aren't captured in a patient specific case.

Funding

In terms of resources, the Department needs 2 Senior Attorneys-PG 230 (PSU) and 2 Administrative Secretaries SES PG 412 (PSU) to handle emergency actions and prosecution of practitioners who are inappropriately prescribing drugs. These can be funded from the MQA trust fund so just budget authority is needed, not cash.

Florida Department of
Law Enforcement



Combating Pharmacuetical Drug Abuse and Fraud

Law Enforcement Resources

Senate Select Committee on Medicaid Prescription Fraud, Abuse and Diversion

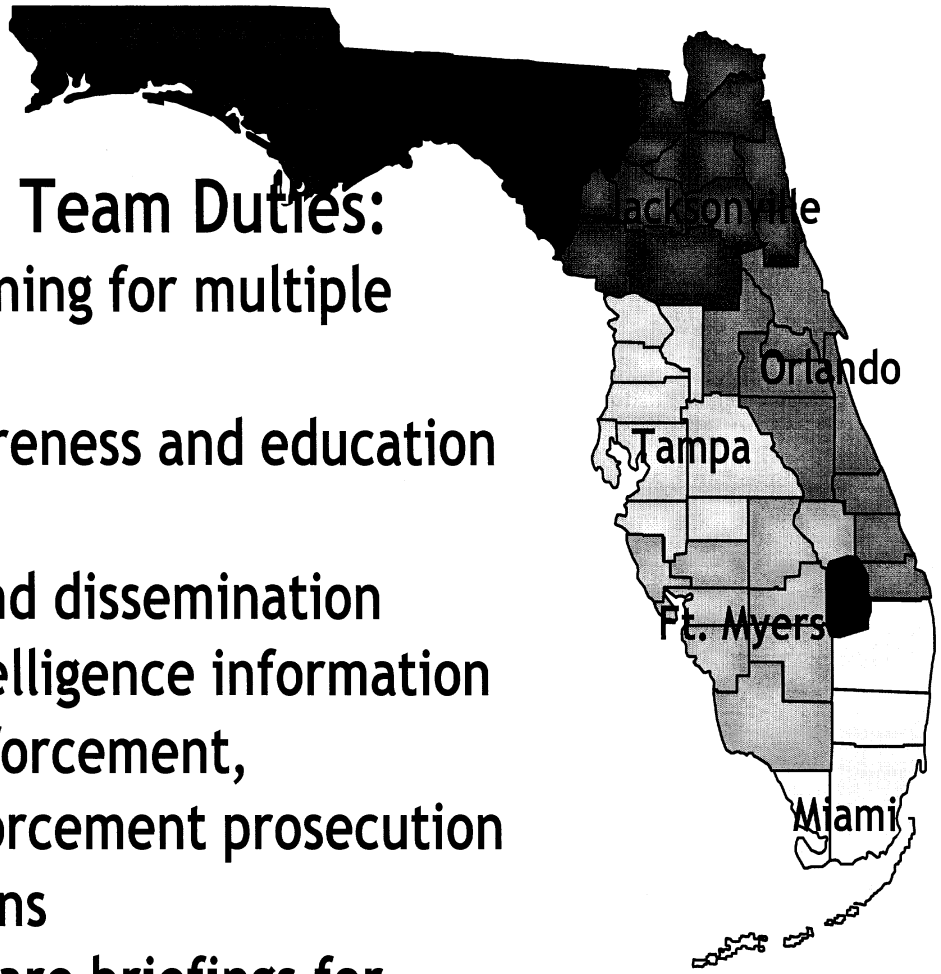
February 3, 2004

FDLE

Sustained Commitment = Funding Committment

FDLE cannot provide the necessary resources to have an impact on prescription drug abuse and Medicaid fraud investigations with current staffing levels.

Proposed Seven Regional Diversion Response Teams (DRT's)



Diversion Response Team Duties:

- Ensure regional training for multiple disciplines
- Assist in public awareness and education campaigns
- Ensure collection and dissemination of investigative/intelligence information coordinate law enforcement,
- Coordinate law enforcement prosecution and regulatory actions
- Meet monthly, prepare briefings for Prescription Drug Task Force Principals

Critical Components

- Requires commitment to the task force concept by all agencies involved.
- Concept will stress liaison and points of contact among each agency.
- Members will not be housed together, but may spend some investigative hours in the same office when co-working a case.
- Each agency will maintain their own records and case management procedures for any cooperative investigation.
- Will require initial upper-management planning sessions to craft details of the liaison and co-case process.
- There is no intent for any agency's investigation to superseded another; a complimentary or parallel investigation is envisioned when practical.

Details

Benchmarks for the first 60 days

- Draft formal MOU/Interagency agreement
- Identify appropriate team members from across the state
- Identify core goals and objectives of the teams
- Assemble test group from participating agencies in Tallahassee for a training and information exchange "test run"
- Discuss communications platforms
- Identify joint cases of interest, develop investigative plan

Immediate Goals

- Receive education on each agency's responsibilities, authority and procedures
- Provide an assessment regarding criminal investigative progress and regulatory enforcement strategy
- Establish a personal communications network

Long-term Goals

- **Successful identification and prosecution of pharmaceutical diversion and Medicaid fraud offenses**

- **Provide a report to the Prescription Drug Task Force and this Committee by December 31, 2004 regarding the progress and limitations of these teams**

- **Establish a formal communications network**

Training and Expertise

Current commitments from professional associations, training organizations and the private sector will allow us to seek increased training for law enforcement without asking for funding . . . at least not this year.

Communication

- Potential formal communication networks will be explored for utility and costs
- FDLE analyst could serve as primary POC for case deconfliction
- Currently no need for legislative or statutory changes

Conclusion

Resources, while critical, will not ultimately decide whether Florida law enforcement has an impact on this problem. The most important step toward success has already been made – a commitment to interagency communication.

FLORIDA MEDICAL ASSOCIATION, INC.

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TO: Senator Burt Saunders, Chairman
Senate Select Committee on Medicaid Prescription Drug Overprescribing

FROM: Francesca Plendl, Director of Governmental Affairs
Florida Medical Association

DATE: January 23, 2004

RE: Emergency Suspension Orders

During meetings of the Senate Select Committee on Medicaid Prescription Drug Overprescribing, the idea has been discussed to increase the power of the Department of Health in regards to the issuance of Emergency Suspension Orders, specifically when a practitioner is arrested for Medicaid fraud. The Florida Medical Association has examined this issue closely, and would like to make the proposal set forth below. We support efforts to control fraud within the Medicaid system while at the same time ensuring that practitioners' due process rights are observed. In addition, it is important to ensure that the Department of Health is not unduly restricted as it proceeds with action against the practitioner's license.

The language suggested below amends Section 456.074, Florida Statutes, entitled Certain Health Care Practitioners; Immediate Suspension of License. The language below *adds a provision to this statute* that will allow the Department of Health to immediately suspend a practitioner's license if the practitioner is arrested for fraudulently prescribing controlled substances to either a Medicaid or Medicare patient. At the same time, the proposal:
1. Allows the Department of Health to make the determination as to whether it it has enough evidence to proceed with the licensure action, by using the word "may" rather than "shall". If the word "shall" is used, it will force the Department of Health to, in some cases, proceed to hearing before it is ready to prove its case, thereby ensuring a not guilty verdict at the Division of Administrative Hearings.
2. Mirrors language already set forth in Section 456.074, Florida Statutes, regarding what practitioners are covered and what statutes are involved.

The proposed change is as follows:

456.074 Certain health care practitioners; immediate suspension of license.—

(1) The department shall issue an emergency order suspending the license of any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, chapter 466, or chapter 484 who pleads guilty to, is convicted or found guilty of, or who enters a plea of nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893 or under 21 U.S.C. ss. 801-970 or under 42 U.S.C. ss. 1395-1396.

(2) If the board has previously found any physician or osteopathic physician in violation of the provisions of s. 458.331(1)(t) or s. 459.015(1)(x), in regard to her or his treatment of three or more patients, and the probable cause panel of the board finds probable cause of an additional violation of that section, then the Secretary of Health shall review the matter to determine if an emergency suspension or restriction order is warranted. Nothing in this section shall be construed so as to limit the authority of the secretary of the department to issue an emergency order.

(3) The department may issue an emergency order suspending or restricting the license of any health care practitioner as defined in s. 456.001(4) who tests positive for any drug on any government or private-sector preemployment or employer-ordered confirmed drug test, as defined in s. 112.0455, when the practitioner does not have a lawful prescription and legitimate medical reason for using such drug. The practitioner shall be given 48 hours from the time of notification to the practitioner of the confirmed test result to produce a lawful prescription for the drug before an emergency order is issued.

(4) Upon receipt of information that a Florida-licensed health care practitioner has defaulted on a student loan issued or guaranteed by the state or the Federal Government, the department shall notify the licensee by certified mail that he or she shall be subject to immediate suspension of license unless, within 45 days after the date of mailing, the licensee provides proof that new payment terms have been agreed upon by all parties to the loan. The department shall issue an emergency order suspending the license of any licensee who, after 45 days following the date of mailing from the department, has failed to provide such proof. Production of such proof shall not prohibit the department from proceeding with disciplinary action against the licensee pursuant to s. 456.073.

(5) The department may issue an emergency order suspending the license of any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, chapter 466, or chapter 484 who is arrested for a felony under chapter 409, chapter 817, or chapter 893 or under 21 U.S.C. ss. 801-970 or under 42 U.S.C. ss. 1395-1396 if the allegations in the case include fraudulent prescribing of controlled substances (as defined in Chapter 893) to a Medicaid or Medicare patient for monetary gain by the licensee.

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TO: Senator Burt Saunders, Chairman
Senate Select Committee on Medicaid Prescription Drug Overprescribing

FROM: Francesca Plendl, Director of Governmental Affairs
Florida Medical Association

DATE: January 23, 2004

RE: Senate Bill 1064

The Florida Medical Association has reviewed Senate Bill 1064, which makes changes to the Medicaid laws which are both substantive and substantial. We support efforts to control fraud within the Medicaid system while at the same time ensuring that patients in Florida continue to receive quality care and treatment. We believe the following changes to the bill will meet both of these goals:

1. Within Section 2 of the bill, on page 10, lines 8-19, a paragraph (g) is being added to Section 409.913(7), Florida Statutes. The current language in the bill would prohibit a Medicaid patient from receiving care or a prescription from a non-Medicaid provider. This would prohibit a physician who is not in the Medicaid program from seeing a patient pro bono or from seeing patients who are dual eligibles (eligible for both Medicaid and Medicare benefits). The FMA suggests that the below language be used instead:

Delete lines 8-13 on page 10 and insert the following:
(g)(1) Are authorized by a Medicaid provider;
(2) For medically necessary medications prescribed by a physician licensed pursuant to Chapter 458 or Chapter 459 to a Medicaid recipient whom the physician has treated without compensation;
(3) For medically necessary medications prescribed by a physician licensed pursuant to Chapter 458 or Chapter 459 to a patient who is eligible to receive services from both Medicaid and Medicare; or
(4) Are otherwise authorized by the Medicaid program.

This language will allow a non-Medicaid physician who treats a patient on a pro bono basis or who treats Medicare patients who qualify for prescription drugs from Medicaid to continue to prescribe medically necessary drugs to those patients. This language still meets AHCA's goal of prohibiting most non-Medicaid physicians from prescribing to Medicaid patients without restriction.

Please note that the FMA has been unable to determine what lines 15-19 on page 10 state, but it appears that these lines may need to be reworded.

2. Within Section 2 of the bill, on page 12, lines 1-8-19, paragraph (h) of Section 409.913(14), Florida Statutes is being altered so that the Medicaid program would be able to seek action against a provider who submits even one erroneous Medicaid claim. The current law requires that the claim either be false or that a *pattern* of erroneous claims be shown. The FMA is asking that the words "a pattern of" *not* be stricken. Taking action against or prosecuting a provider for just one erroneous claim will result in unnecessary actions by AHCA and will keep good providers out of the Medicaid system. This change in the law does not help to deter fraud and will result in a reduction in the provision of quality health care for Medicaid patients. This language should not be stricken from the current law.

3. Within Section 2 of the bill, on page 16, line 1, paragraph 24(a) of Section 409.913(14), Florida Statutes is being altered so that the Medicaid program would be able to withhold Medicaid payments from a provider indefinitely. Currently this may only be done "pending completion of legal proceedings." The bill proposes to strike the words "pending completion of legal proceedings." This is simply draconian and should not be part of this bill. Again, this change in the law does not help to deter fraud and will result in a reduction in the provision of quality health care for Medicaid patients. This proposal should be taken out of this bill.

4. Within Section 3 of the bill, on page 17, lines 17-31, paragraphs (2) and (5) of Section 409.9131, Florida Statutes is being altered so that peer review in the Medicaid program, which helps to ensure the integrity of the program by providing for medical expertise and review, would (a) no longer include the determination of whether the documentation in the physician's records is adequate – AHCA staff would be able to make this determination without input from an appropriate medical professional and (b) would require that physician peer review be limited to a review of: medical necessity, appropriateness and quality of care - currently, peer review of physician claims is not limited to only those determinations.

Peer review prior the initiation of formal proceedings by AHCA is a hard won benefit for Medicaid providers. It is an important part of the due process that has been granted to providers and taking a substantial part of this away will impact on good providers staying in the Medicaid program which ultimately hurts only patients. This change in the law will not help to deter fraud and will negatively impact patients.